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ABSTRACT

Four conference papers center on educational strategies for use with emotionally distrubed epileptic, the multuply handicapped retarded, hospitalized, and learning disabled children and adolescents. Special education at the National Children's Rehabilitation Center for emotionally disturbed epileptics is said to stress optimum learning through means such as teacher observation of child behaviors, the formulation of hypotheses regarding the observed behaviors, and a variety of teaching strategies. A paper on techniques in behavior modification used with multiply handicapped retarded children gives practical do's and don'ts such as don't expect overnight results and do carefully select the target behavior. Examined are the roles of the teacher in an ungraded open classroom at a children's hospital, and questioned is the relevance of present teacher education. A program of activized milieu therapy for learning disabled or emotionally disturbed adolescents is explained to include active involvement with younger children and projects, discipline by one's peers, counseling, and the application of the case study technique to self understanding. (DB)

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Exceptional Children Conference Papers: Behavioral and Emotional Problems.

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TEACHING THE EMOTIONALLY DISTURBED EPILEPTIC

Introduction

One of the debatable questions of today is "What is special about Special Education?" This question is often asked about the educational program of the National Children's Rehabilitation Center. If it is different, why is it different, in what way, and how is such a program developed?

History of the Population:

With the age range of seven to seventeen years, even our youngest students have encountered educational expectancies and met defeat. It is ironic that some have "failed" kindergarten - and, in some cases, Head Start! Others have started off well and then met failure in their third or fourth year, or even as late as the ninth grade. This usually coincides with the onset of seizures, but often there have been ongoing problems that were exacerbated by epilepsy. It must be noted that the students who have entered N.C.R.C. have not been able to attend school successfully because of seizures and behavioral problems. They have often been moved from an average educational setting to a special class or private school and still met failure, which has resulted in expulsion. Although homebound instruction has sometimes been provided, this has resulted in further deprivation in social learning.

In summary, these students have met academic failure, presented behavioral problems incompatible with even special class placement, and lack the social and emotional controls required to reintegrate themselves back into society as adults. These are the problems which the educational program of N.C.R.C. is designed to ameliorate.

Organizational Pattern of the School:

Students are grouped into five nongraded classes averaging twelve students each on the basis of social maturity. The academic level of functioning varies from three to five years. Each student attends five one-hour sessions in classrooms organized as content-oriented learning centers: Language Arts, Math, Social Studies-Science, Phys Ed and Woodshop. The classes move as a group to each learning center.

With the varying functioning levels, learning disabilities, and emotional problems of each student, it is necessary to staff each classroom with at least one teacher and a teacher-aide, thus providing a ratio of 1:6. Additional personnel consist of a school secretary and the Education Director.

Educational Goals:

The goal of the Education Section of the National Children's Rehabilitation Center is very simple: to develop a setting in which each

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student can attain a functioning level of optimum learning. This must give consideration to his past history, his self concept, his current level of functioning and his social skills. It is in these areas that N.C.R.C. becomes "Special".

Observation of Child Behaviors

In planning for the development of the optimal level of learning, adequate observation is needed to determine the current status of the child's level of functioning. The psychological rationale for the validity of using observable behavior can be summarized in the following concepts:

1. The observed behavior can give information about the child's current level of functioning.

2. Each behavior is the child's response to a given stimulus or set of stimuli.

3. The child is responding with the best behavior of which he is currently capable.

The first prerequisite then becomes one of observing and recording specific behaviors that furnish information about the current level of functioning. These observations can be recorded in the following areas:

1. Physical Development

   a) What are his gross and fine motor responses?
   b) Does he have perceptual strengths and/or weakness?
   c) What is his tempo and pattern of movement?

2. Academic Functioning

   a) What are his perceptual-sensory-motor skills?
   b) Is he able to follow directions?
   c) Does he use past experiences as aid to learning?
   d) Does he show interest in specific topics or areas?
   e) What is relationship of his current level of functioning to his C.A.?

3. Emotional Responses

   a) What is his response to new situations?
   b) How does he show fear, anger, happiness?
   c) Does he have habitual responses of expressing emotions?
   d) What is his response to failure, success, frustration?

4. Social Maturity

a) How does he interact with peers, staff?
b) What is the nature of these interactions?
c) Is he an isolationist, leader, or follower in the group?
d) How do his social interactions reveal his self-concept?

5. Sexual Development

a) How does his body concept reflect his sexuality?
b) Is he aware of his sexual role?
c) What is the level of his sexual maturity interactions?
d) Does he make appropriate sexual differentiation in social interactions?

6. Motivation

a) Does he verbalize the purpose of specific behaviors?
b) Is there an observable source of drive which evokes given behaviors?
c) Does he express his value system by the behavior?
d) Is he responsive to peers/adults as change agents?

Hypothesis

The second prerequisite for learning is the formulation of hypotheses regarding the purpose (s) of the observed behaviors. This requires skill and training to analyze the recorded observations as clues to the rationale of the child's responses. Too often the child is considered obstinate, passive-aggressive, rebellious, hostile, or even stupid! Surface acceptance of these characteristics as status quo closes the door to the realization that the child has no other repetoire of responses to deal with the environment. It is in this area that the teacher must look for clues as to what any given behavior does for the child to alleviate frustration, anxiety or to evoke attention. Often the global classroom situation will be the stimulus for the behavior; at other times, it may be the specific educational task; or it may be individual peers or adults. The task then becomes one of drawing inferences from the series of discrete observations to formulate specific hypotheses as to the purposes of the individual behaviors. These hypotheses form the basis for the teaching strategy.

Teaching Strategy

In an average class, the teaching strategy is usually based on a curriculum guide for the grade level and ability of those students. The focus is on academic skills and concepts that are accepted as desirable for an educational program which follows normal developmental process. The students of N.C.R.C. have not been able to accomplish these objectives. Their emotional and social maladjustment, often complicated by an active seizure disorder, has interfered with their ability to learn. The teaching strategy must include consideration of these factors as an educational program is designed for each individual student.

The teacher observations furnish the specific information about each child that is needed to formulate the individual teaching strategies. However, the teaching strategy for children at N.C.R.C. goes beyond the analysis of academic skills. It uses the information gained by observing his emotional responses, social skills, type of motivation and physical characteristics as factors which influence his current level of mental functioning. The failure to learn as other children do has introduced the factor of past experiences as a negative inducement to try again. A child who has mastered his addition and subtraction facts through nine should be ready to begin learning them through nineteen. However, he may exhibit many behavioral problems when he is expected to begin a task that is new, that holds the possibility of failure (errors) and holds the potential threat of validating his inability to learn. These are the dimensions that are critical in planning a teaching strategy for these students. In summary, the teacher must have behavioral evidence of a child's current academic skills, self concept and his physical, emotional and social responses, to plan an educational program that can provide the educational program in which he has the best prognosis for learning.

The program must be based on the hypotheses that have been formulated as to the purposes of the observed behaviors.

Evaluation

It is critical that a procedure for evaluation be included in the planning of the teaching strategy. This should include three methods. First, on-going observation and recording of behaviors is essential. This furnishes specific information about each task, the student's responding behavior and the effectiveness of the learning activity. Repeated observations furnish details regarding the changing emotional and social factors introduced by the teaching strategy.

Second, evaluative procedures should include informal testing. Primary data can be collected from daily written work, participation in oral work, projects completed, and concept information. Informal testing can also be done through quizzes, Informal Reading Inventories, and tests that are included in the texts and workbooks. Again, teacher observations are essential to note social and emotional problems that influence the student's ability to demonstrate his competencies in these situations. This is important data for future teaching strategies.

Lastly, formal (standardized) testing should be done. Metropolitan Achievement Tests, Stanford Achievement Tests, WRAT, Gray Oral Reading Paragraphs, Gates Reading Summary, the Peabody Picture Vocabulary Test and/or ITPA are administered. Achievements tests are given within the first thirty days of residency, and retests are administered at the end of each school year. Other tests are used when more diagnostic information is needed.

The teacher can also request formal psychological testing by the clinical psychologist. This includes one or more of the following: Benet, WISC, Bender-Gestalt, TAT and the Rorschach. This testing is done at N.C.R.C., but outside of the school setting.

On the basis of these evaluation procedures, the teacher reviews the hypothesis for the teaching strategy. If the hypothesis is validated, then the teaching strategy is continued as planned, with revising for new levels of competency as needed. If the hypothesis is found to be invalid, new ones must be formed on the basis of the new information gained from the evaluations, and new or modified teaching strategies must then be formulated.

To summarize: once the teaching strategy has been developed, evaluation procedures are necessary to validate its hypothetical construct, determine its effectiveness, and to plan for revisions as new learnings occur. It must reflect student growth in academic skills and social and emotional adjustment. It is a continuous and dynamic process that is operative for the full time of residency.

Understanding the Child

The effectiveness of the teachers' ability to plan the teaching strategy and its revisions will 1) reflect his understanding of the child and his problems; and 2) form the basis for his relationship with the child. The term "understand" is used to denote the awareness of the child's behaviors, a validated hypothesis of the purposes of these behaviors, and the ability to predict the resulting behaviors expected within the teaching strategy. This understanding is based on the knowledge gained through observation, testing, and the child's responses to the teaching plan.

As the teacher's understanding deepens, he is able to provide the educational program in which the child will meet academic success. He will be able to provide for the emotional and social growth that plays such an important role in regaining mental health. The child's self concept will change from a negative attitude of being stupid, worthless and damaged, to a positive one of seeing himself capable of learning, of being able to form interpersonal relationships with peers and adults, and capable of becoming an adult in his own community.

It is this thoroughness of understanding that forms the basis for the last prerequisite of optimum learning.

Relationship

The educational literature often mentions structure as an integral part of the educational program for exceptional children (Cruickshank, et al). This is defined by Rappaport as the -

. . . ability of the adult to understand the child sufficiently

> well at any given moment, through his verbal and non-verbal communications, to relate in a way which aids the child's development of impulse control and other ego functions.[1]

The development of viable relationships can only be formed on the foundation of this structure. As discussed above, there are many steps leading to the formation of relationship between the teacher and each child. There must be a positive attitude of expectancy that his inappropriate responses can be changed to approved behaviors. The intent of helping the child learn new behaviors must be transmitted. Unless the teacher feels that he can help the child, the teacher will not be able to feel good toward the child. If the teacher cannot feel good about the child, the child cannot feel good about himself. Rappaport states -

> If your relationship does not communicate that to the child, you cannot help him build skills, you cannot aim to achieve more adaptive behavior.[2]

Optimum Learning

It has been the purpose of this paper to discuss the prerequisites for optimum learning. Learning will occur at each level; however, optimal learning will only take place when a relationship has been built between the teacher and the child that provides the total structure necessary for him to feel secure in his interactions with the teacher, because he knows that the teacher understands him. This is based on the teacher's knowledge about him, the teacher's consistency of feeling good about him, the teacher's expectancy that he can learn, and that he is a worthwhile human being.

The following diagram summarizes the prerequisites for optimum learning for the students of N.C.R.C.

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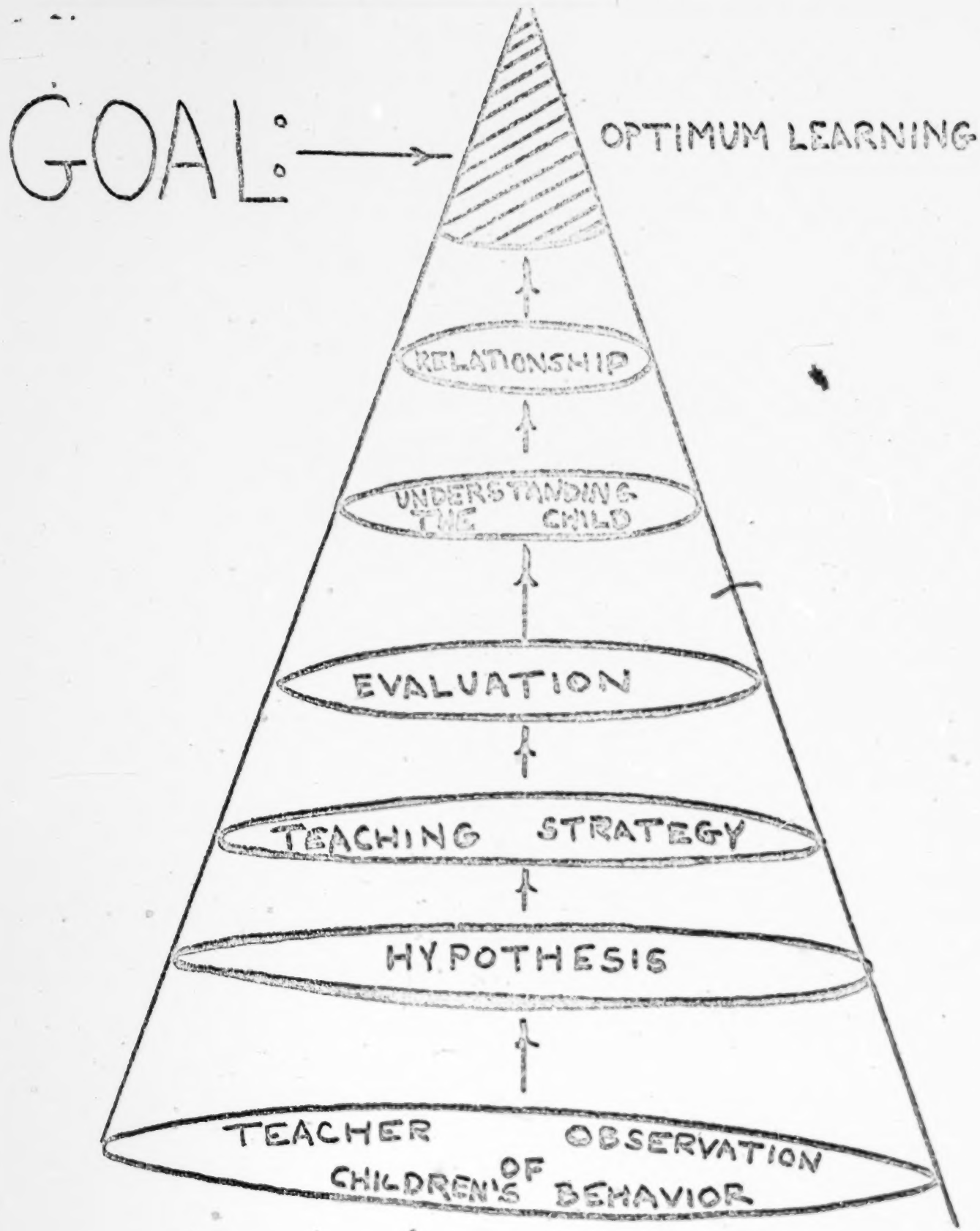
1 Cruickshank "Education of Exceptional Children and Youth", p. 269
2 Ibid. p. 271


GOAL:
OPTIMUM LEARNING
RELATIONSHIP
UNDERSTANDING THE CHILD
EVALUATION
TEACHING STRATEGY
HYPOTHESIS
TEACHER OBSERVATION OF CHILDREN'S BEHAVIOR

TECHNIQUES IN BEHAVIOR MODIFICATION

Marvin M. Malcotti

Rosewood State Hospital, Maryland

When working with the multiply-handicapped retarded one must remember that behavior modification is not a way of explaining a particular behavior. The organism is responsible for the changing of his environment to receive the reinforcement that the behavior modification program offers. The reinforcement technique may allow one to change such cognitively structured things as attitude as well as other behavior. Behavioral principles may be used to bring a child through the beginning Piaget sensory-motor experiences, and to enable him to make greater strides in involving himself in his environment. The effective use of behavior modification techniques in an educational situation is dependent on:

1. clearly defining the behavior to be changed or emphasized;
2. evaluating the context in which the behavior occurs with particular attention to the antecedents and consequences;
3. determining appropriate reinforcers;
4. the consistency with which the program is implemented.

These techniques may be used with an individual child or with a group, and, with proper instruction, the program can be transferred into the home or cottage. Behavior modification can be an effective component of a total program and, as such, can facilitate the progress a child makes in many dimensions.

Without getting into the scientific jargon of it, I would like to share with you some practical ideas regarding behavior modification.

DONT'S:

1. Don't assume that by reading printed materials on behavior modification you will be able to modify behavior. Practice with different techniques, and develop a program which fits the needs of the child and his environment.

2. Don't expect your results to occur overnight. For some children, behavior modification is an on-going process. Proper stimulus control must be maintained for results to occur.

3. Don't ever "go it alone". If a program is to have any success, you must draw in all people involved with the child and/or his environment. Get them to comment on the behavior of the child in the situations with which they are familiar. It is important to have input.

4. Don't ever assume that the only problem a child has is mental retardation. Mental retardation is often a symptom of a syndrome. This is an especially important reason for involving other people in your programming.

5. Don't ever recommend institutional placement for a difficult child unless it is absolutely necessary! The dangers of institutionally-produced retardation are great.

6. Don't ever assume that a child is so low-functioning that he is untrainable. It is up to you to bring responses out of the child through programming for his needs.

Be careful of 24-hour-a-day programs. Plans for every minute of the day may not really meet the child's needs properly. Plan for and block out a small portion of the day. Often behaviors that you feel need modification may only exist during certain situations at certain times of the day. Get other people involved and working with the child so that everyone assists and is informed of the child's program.

7. Don't ever assume that behavior modification is the only way to program for a child.

DO's:

1. Consider the three classes of behavior modification programming:

   a. Building in: introduce some set of responses for their own sake. Build in responses to such things as feeding and self-care.

b. Fading out: fade out some behaviors for their own sake: such behaviors as hyperactivity, self-abusiveness, and withdrawal.

c. The use of these techniques may help to bring the child through a stage or a pattern of behavior which has held him back from the next developmental level.

2. Be very practical in the selection of the behavior you are interested in programming. Be careful not to create overblown programs, and keep accurate records to find out what is happening.

3. Use the proper equipment for record-keeping. The following are some useful record-keeping materials available from Behavioral Research Co., Kansas City, Kansas:

a. wrist tally board

b. the tally card box

c. timer (minute)

d. counter

e. golf score keeper

f. cook's timer

All of this equipment is designed to assist in charting and counting behaviors. They are small, inexpensive items which are easily carried on the person.

4. Most behaviors are caused by antecedent environmental conditions, though other factors may enter into the causation. It is therefore important to have as much input as possible from the people who know the child's psychological aspects.

5. Use small steps; build in proper responses, and fade out inappropriate ones gradually.

6. Stress greatly the use of parents in your program. Keep them well informed on programming and progress, and get them to execute the program when possible.

DEMONSTRATION

Two children, a hyperactive five-year-old and an extremely passive motorically involved 15-year-old, were the subjects for a demonstration involving the use of behavior modification techniques.

The initial phase of the demonstration involved observing and recording the frequency of a particular behavior: i.e., did the hyperactive child leave his seat? how long did it take the passive child to reach for an object? In the first instance, the emphasis was on increasing length of time the child remained in the chair; in the second, on shortening the amount of elapsed time between presentation of an object and the child's response to it.

Both children reacted favorably to tangible reinforcers, but not to adult praise. Immediate reinforcement was used for the passive child, intermittent reinforcement for the hyperactive child.

Discussion subsequent to the demonstration focused on the use of demonstrated techniques in a classroom situation.

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" Teaching Roles and Their Implications for Teacher Education"

Janice Ann Tessier
CEC Convention
April 24,1973
Blythedale Children's
Hospital, Valhalla,N.Y.

OSE 100

March 18, 1973

Dear Miss Giales:

Enclosed is a copy of my speech to be presented on Thursday, April 2[illegible], 1973 at the CEC Convention in Dallas. Please make it available for the ERIC file, and for distribution at the convention.

Thank you for your efforts.

Sincerely,

Janice Ann Tessier

Once upon a time there was a teacher. She worked in a small building in the center of town. She was respected by students and parents. She kept long hours and received very little pay. She lived to see most of her students grow up and was later teaching their children. The teacher would close her door in the morning and when the bell rang school was dismissed. Her integrity, the curriculm, discipline and accountability were held, and questioned by herself, or perhaps by the town. As time went on she became a public servant whose private life was equated with professional integrity. Unfortunately the story does not end with a "happily ever after", for as simplistic as the one-room school house appears to us------- it too had its problems.

However, these problems have increased in geometric proportions to the extent that the teacher is forced to say "I am no longer a public, passive servant of the community, but rather an active, vibrant, complex individual who must play many roles while performing one basic function-----that being the developmental growth of each child shared with us to be educated. The two-fold question we are faced with then is: "What are the "roles" of the teacher, and are we preparing teachers, and replenishing teachers with the skills necessary to meet these "roles"? "

To define the "role" of "teacher" I have chosen to quote from Kahil Gibran's The Prophet.
"Then said a teacher, Speak to us of Teaching.
And he said:
No man can reveal to you aught but that which already lies half asleep in the dawning of your knowledge."

So in the role of active teaching, the teacher is responsible for the development of the child's intellectual, social, emotional and physical needs. At Blythedale Children's Hospital we have chosen the philosophy of the "Open Classroom" to meet these needs. Our children are placed in family groupings of 5-7, 7-9 10-12 and secondary students who operate in three mini-schools. The children are heterogeneously grouped in intellectual abilty, ranging from the severe to the gifted, social class, and severity of physical disability. We are primarily a therapeutic hospital which provides physical, occupational, and speech therapies to children referred from other hospitals. The hospital philosophy believes that no child should be restricted to a bed. Therefore every child has a vehicle which gets him to school and recreation therapy.

The children are encouraged to lead as "normal" a life as possible. We have found that a child who is encouraged to use what is positive about himself tends to get well much faster. Our school program is Union Free School District #6 in Valhalla N.Y. We are a public school and operate on a 12 months basis. This presentation is illustrated by my present experience as an Early Childhood teacher.

Though teaching roles may seem more obvious in a hospital setting, they are indeed present for every teacher. The teacher as "teacher" must find ways to be the catalyst for learning. She supplies the motivation, enthusiasm, and concepts to the child. To do this, she must know where the child is functioning. Which leads us to the role of the teacher as diagnostician.

Given an interdisciplinary setting the problem of assessing a child's learning abilities is not so great as the teacher operating in a purely educational setting. Nevertheless, the assessing of each child to find his mode of learning is the responsibility of the classroom teacher. She may use prepared diagnostic materials, or develop one of her own. We have found that combining the two approaches give the more realistic picture of where the child is, and how he learns.

The next step is the prescription and formulation of goals. We assess our children on a 3months basis. This is in part due to the fact that the children's stay varies from 2 months to two years, and also to adjust the child's program according to his changing needs. The children are encouraged to participate in the writing and evaluation of their goals. The child's progress is shared at interdisciplinary conferences and made part of his permanent hospital records.

The next role is that of "Recorder" or "Secretary". A teacher needs to find a means of documenting the child's accomplishments and problems. We have chosen to write a weekly goal sheet and each member of the team records the degree of accomplishment each child has made. On a weekly basis the child's goals are reevaluated toview the realistic appraisal of his meeting the finial goal. Our goals are written in terms of instructional objectives. This goal sheet is accessible to volunteers, and students who are working with the children, while serving as a written record of the child's progress.

In addition we have instituted using individual contracts with the children. The degree of reponsibility is relative to the child's readiness and capabilities. However, each child daily records his affective, and cognitive skills. This serves to allow the child to be involved with his curriculum, be responsible for its accomplishment and gives him a concrete piece of evidence of his growing skills. At the same time it fosters our final goal for our children to be independent, and self-directive.

The teacher also needs to record or assist in the recording of classroom activities and discoveries. Charts, graphs, class books, sharing time, and displays are some of the ways we have implemented individual and shared learning experiences with the children.

Obviously, it would be difficult for a teacher to implement all of this by herself. However, one of her "roles is for teacher training. It may be a volunteer, or a student teacher,and yet your greatest assistants are the children themselves. It is with great enthusiasm that children share the teaching role to their peers.. In this way every child has something to offer to another child, the class or to the teachers. The teacher is also concerned with the training of paraprofessionals, students and volunteers, who work in her classroom. She must find the time for orientation, communicating,and skillbuilding if these "Aides" are to be effective in her program. It may also mean giving up some of the active teaching of a lesson, or perhaps allowing a failure to occur as a learning experience.--but again it places a demand on the teacher and one too often she is unable to meet effectively.

Another role of the teacher is an involvement with the child's physical development. The teacher is responsible for the "carryover" of all therapies the child is involved in. The teacher needs to understand the positioning, equipment and goals of the therapies involved , and implement these in the child's educational program It is important that the child receive only one set of signals from the interdisciplinary team. She must be sensitive to the child and therapist, reporting changes, problems, and progress to all disciplines involved.

The teacher is a member of the interdisciplinary team. She must be able to explicitly communicate the child's educational and affective progress. She is a vital member of the team, and needs to be equipped to communicate with all disciplines---- medical, social service, psychological, or therapeutic.

The most important however, of all the"roles", is the role of the teacher as a significant affective person in the child's life. The responsibility here lies in developing sensitivities to what a child is feeling. It is in loving, in disciplining, and in knowing that "love is the modifier of behavior". It is when a child knows that the teacher cares enough to limit his behavior, or cares enough to let him cry, or be angry ; in caring enough to give him the kiss or hug, the word of praise--- in essence that you value him as a real person.

The"roles"of the teacher also include being an active community organizer. She is in the position to influence community change. In auummary, the"roles" of the teacher increase with the complexities of the

of the society we live in.

I ask the following questions:
"Are Teacher Education programs giving students enough real experience with the "roles" they are to face in the classroom?
Can the student who spends most of her college experience passively being lectured to, be equipped with the skills to deal with individual problems of the classroom?
Can the student, or teacher give experiences of discovery, and communication, if she has never experienced it in her own education?
Is she equipped with real skills in handling discipline problems outside of the textbook?"

Perhaps it is time for Teacher Education programs to look at the problems of the new teacher, and experienced teacher and answer the question "Are we training teachers in the way we expect them to teach children?

In summary I would quote Plato 427 BC.
"Education is a lifelong process"
And in that context the teacher is in need of leadership traing to enable her to meet the ever varied roles she faces in the classroom.

ACTIVIZED MILIEU THERAPY

A digest of presentation by
Dr. Irwin H. Wexner, Headmaster
THE ADAMS SCHOOL

Activized Milieu Therapy is a mobile program that gives the learning-disabled adolescent a real learning experience in doing - in achieving responsiblity. The programs are geared to giving the hyperactive an outlet for doing, and activizing the unmotivated older adolescents: guiding younger children, managing their charges at lunch, teaching sports, running clubs, governing student affairs.

A particularly popular program for the older children is that of Teacher Assistant in the Early Childhood Center, the Lower and Junior Schools, gym, library, etc.

Another positive activity is in our Social Studies classes where seniors are encouraged and guided in electioneering and campaign issues, discussing consumer problems and the issues of the day.

The Adams School finds that a climate of teaching emotionally-disturbed adolescents to learn by doing has a tremendous therapeutic value for those not reached through traditional psychiatric involvement or remedial measures. Programs such as publishing a literary-art annual that is a forum for ideas and an outlet for creativity is also a discipline in productivity. Expressive art in oil, sculpture, collage and color is encouraged: impressive art is also participated in by visits to galleries, artists' ateliers, walks through Greenwich Village. Improvisational acting,

pantomime, music and words are the exciting elements of the expressive experience. Films, film making, and photography are other popular means of expression.

Gym student leaders work with younger students who are poor in co-ordination and learn the principles of perceptual training themselves in the process.

"Practical doing" is brought inside Adams through sub-contract work with firms such as Bell Telephone, direct mail houses, manufacturing concerns who bring their work to the Adams Career Center to be done by its students. The young people get course credit and pay, business skills and training and release through "doing."

The consequence of the Activized Milieu Therapy program stresses "we agree you may have had all the bad breaks but what are you doing to elevate yourself above them. Students are judged by their peers. Members of the psychology class make up the student advisory committee. The headmaster, a psychologist, a level director and a teacher serve as resource consultants.

Students who need corrective behavior measures may be referred to this committee. This concept is tremendously therapeutic for younger children who think highly of their peers to see the democratic process. Again it is also therapeutic for the advising group who are probably committing the same infractions to see themselves in a non-threatening mirror.

Lastly, having a direct part in deciding whether a student should be

discharged for an incorrigible offense is a strong factor in teaching that there is a consequence aspect to one's acts.

Activized Milieu Therapy must be experiential, and the experiences must manage the dialectics of the concrete and the abstract. There must be a personal and social consequence for what one does or doesn't do. The consequences, preferably positive, must develop insight and lead to improved behavior rather than end with a punitive restriction.

Both the methods and the goals of the experiment in Activized Milieu Therapy have to be rewarding, self-directive and self-evaluative for the participants.

An emotionally-disturbed adolescent must see the fruits of his labor quickly. He is impatient and demands immediate self-gratification. In milieu therapy this must be recognized and granted; all the while we work to stretch his patience period. It must give -- and then ask -- to help postpone the need for prompt pleasure. It must teach him to correlate his personal needs, interests and rewards with those of a larger social circle.

The emotionally-disturbed adolescent is mature in size and often early experienced in the ways of the world -- or the street. But his disturbance makes him immature in many ways at the same time.

Because he lacks or mis-applies direction, the emotionally-disturbed adolescent needs step-by-step experiences and guidance in confidence building

usual for the younger. These must be pre-structured by staff and co-structured with the student as he goes through these experiences and guidance.

Some emotionally-disturbed adolescents don't know their problems. Others feel the effect of the symptoms but don't fathom the causes. Some are taught early to deny both the causes and the symptoms -- or shift them to less hurtful labels.

Still other emotionally-disturbed adolescents know or feel their inner hang-ups full well. But being reminded or evaluated or criticized by outer forces is a threat which only increases denial through misbehavior or poorer functioning.

It is this cycle of threat, misperception, action and reaction that demands reward or operant conditioning as a short-circuit to denial. It is this cycle that demands direction and evaluation be emphasized upon <u>self</u>.

The opposite of the consequence mechanism appears to be the reward system. Both, however, are treated as two sides of a single behavior coin. People and situations react in like kind to the way you act.

The final goal of milieu therapy for emotionally disturbed adolescents must be the creation of strengths for <u>self</u>-directive and <u>self</u>-evaluative patterns of behavior. There must be dozens of opportunities daily for them to see the <u>results</u> as they direct or evaluate their own acts and ideas. They must do this self-directing in an environment that is simultaneously structured to consider the needs of other.

Counseling is a cornerstone of milieu therapy. Doing, providing experiences, and reversing roles offer ego-building opportunities. There must also be a time for direct approach to the problems that brought these adolescents to a scene of special education in the first place. Counseling, in these nine years, has evolved into several forms: group counseling once a week with a staff psychologist; individual counseling either programmed or available on a crisis basis; career counseling; college counseling; and guide group where the teacher and group resolve "local" problems. We don't promise intensive psychiatric therapy. But we don't deny, cover up, or mis-label the problems all of us know need resolution.

As part of our program of insight-development we have the "open-admission" aspect of direction and evaluation by students themselves. The first is having our students address conferences. Each year they speak at staff meetings, in-service courses, Parent Association meetings, or professional conferences. They not only learn much of themselves, but they also teach their audiences most effectively.

The second experiment in self-direction and evaluation is through the case study technique. They are taught the ingredients and procedures of a case study and each does first, a study of someone impersonal; second, a study of someone a bit closer - one of the younger students they teach. Finally, come the studies of themselves. By the time they get to the end of this three-step process, there is an almost dramatic quality to the growth of their insight, to the changes in their behavior. When successful, it is the epitome of self-evaulation and, we hope, better self-direction when they leave us.

Some emotionally-disturbed adolescents must see what's happening. Looking it up or writing it down just doesn't get through. They have to feel the impact of an idea. Sometimes the visibility is direct, instantaneous, forced, and head-on. Othertimes it must arise very subtly beneath the surface of time and activity, given a chance to mellow.

Finally, we must teach these particular young adults -- directly and indirectly -- the therapeutic principal of homeostasis. Their lives were -- and often are -- imbalances of emotions. They are distinguished by high points of stress, low points of failure. We have tried to bring a bit of balance to ease the hurt that comes from extremes, especially depressive ones. For each interest-based aspect of program, there must be one that is need-accommodating.

If a student reverses his letters, miscolumns his numbers, misperceives the objective, he must receive Perceptual Training. It must be daily training in class and in special facilities for this disorder. Where there is an organic disorder, the misperception is visual, auditory, tactile. Where there is psychic disorder, the misperception is judgmental, social. In much of our population, both are found.

In conclusion we find the weaknesses of the program are many and the problems are powerful. However, problems are surmountable, and we hope our program and others will tackle them to bring greater mental health to the millions of today's troubled adolescents.

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